**State of Idaho, Department of Administration, Office of Insurance Management**
**Boise, Idaho January, 2002**

**State Employee Insurance Benefits**

# *Fact Sheet*

## *Historical Perspective*

The Office of Insurance Management (OIM) has operated under the principle that benefits provided to State of Idaho employees, whenever possible, be comparable to those provided by other major employers in Idaho. **The most comprehensive coverages available are negotiated based on the funding appropriated annually by the Legislature**. The current appropriation is $382.83 a month, or $4,594 per FTP per year. This includes $7 per month subsidy of the retiree medical plan costs, and $2.61 per FTP per month to fund the reserve from which the State contribution is made for employees on disability and $7.94 per FTP per month for the Integrated Behavioral Health Plan.

**EMPLOYEES, RETIREES & DEPENDENTS COVERED**
**AS OF 7/1/01**

| | |
|---|---|
| **Employees** | **19,115** |
| **Retirees** | **2,964** |
| **Dependents** | **25,684** |
| ***Total*** | ***47,763*** |

Prior to July 1974, each agency negotiated benefits for its employees. With the enactment of **Idaho Code Sections 67-5760 through 67-5772** creating the Office of Group Insurance, the authority and responsibility for the negotiation and placement of group insurance benefits for State employees was centralized for all State agencies.

In FY75, benefits began as a comprehensive major medical benefits plan (front-end deductible required before expenses were reimbursed at 80%). The plan was administered by Blue Shield for employees in North Idaho and Blue Cross for employees in Southern Idaho. In FY76, the State moved to a Basic/Major Medical plan where certain benefits were paid prior to the individual having to meet a $100 corridor deductible and 80% reimbursement. At the same time, Blue Shield won the bid to administer the whole plan.

The State returned to a Comprehensive Major Medical plan in FY84. At the same time incentives were added to the plan to encourage employee use of lower cost medical services.

In FY87, the Office of Group Insurance implemented a Dental Assistance plan in which services were reimbursed based on a fee schedule. There was no coverage for Major Care such as crowns, bridges, dentures or orthodontia. The normal State contribution was funded for the first two years with surplus funds in the Group Insurance Account; the Legislature provided an appropriation for the State contribution beginning in FY89.

Since FY91, the State has made a commitment to paying a larger portion of dependent coverage; subsidizing the retiree plan rates; and allowing for the implementation of a monthly charge to build a reserve from which to pay the normal State medical/dental contribution for disabled employees for up to 30 months. A state-funded Employee Assistance Plan (EAP) was implemented in FY 91 as an employer benefit to provide supervisory assistance, HR consultations, training, and some employee counseling services. Multiple plan choices were offered in FY94 with the implementation of HMO and Modular Indemnity Plan options. Effective July, 2001 funding for the EAP and the mental health/substance abuse benefits formerly provided under the medical plans was used to implement the Integrated Behavioral Health Plan.

**GROUP INSURANCE MONTHLY PREMIUMS**
**State Contribution**
**FY 88 THROUGH FY 2003**

| | | | |
|---|---|---|---|
| **FY88** | **76.01** | **FY96** | **244.58** |
| **FY89** | **88.83** | **FY97** | **244.58** |
| **FY90** | **110.50** | **FY98** | **247.02** |
| **FY91** | **150.29** | **FY99** | **269.84** |
| **FY92** | **163.41** | **FY00** | **298.80** |
| **FY93** | **190.58** | **FY01** | **340.56*** |
| **FY94** | **232.91** | **FY02** | **382.83*** |
| **FY95** | **232.91** | **FY03 est.** | **403.08*** |

***Includes 7.94 per month for IBHP.**

## *How the Insurance Plan Works*

The State makes a monthly contribution toward the cost of the medical/dental coverage for each employee. **The monthly State contribution is the same for each employee, regardless of the plan the employee chooses**. The appropriation for the State contribution is based on the plan which covers the majority of the State employees. That plan has been, and continues to be, Module 2, one of the the indemnity plans underwritten by Regence Blue Shield of Idaho.

**Seventy (70%) percent of all eligible employees enroll in Blue Shield Module 2,** with higher deductibles and stop loss limits. Module 2 has the lowest employee-paid premium rates. Employees electing Module 1 or the Blue Cross Point of Service plan have higher monthly payroll deducted premiums.

The basic principle of a "group" insurance plan is to spread the "risk", or medical/dental costs of a large group over all participants. This results in more affordable monthly premium rates, particularly for those in need of higher levels of health care service. In some years, there will be employees paying premiums into the plan who will not receive reimbursement from the plan because they do not have any health care expenses, or the little they do have falls within deductible limits. Statistically speaking, in one out of ten years that individual will have need to use the benefits as the result of a catastrophic medical illness or accident. As members of the group age, claims can be expected to increase due to the aging process. Our rates can be expected to increase as claims levels increase. Currently, the average employee age on our medical plans is 45.

*Continued...*

## How the Plan Works, cont.

Offering more than one plan option to employees is primarily a means of giving employees the choice to enroll in a plan that best suits their own needs and/or the needs of their families. Those anticipating or needing higher levels of medical care will seek out the plan which provides them the best deal when they need care; the plan that best covers their particular health needs or requires the least amount of out-of-pocket expense to them. This would include the monthly premiums as well as deductibles, co-insurance and co-payment amounts required under the plan.

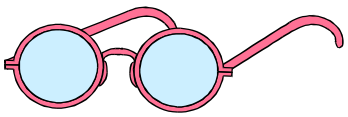
The overall impact of providing multiple plan choices "fragments" the group into sub-groups with different demographics and health status. If a higher number of employees with health problems enroll in a particular group because their actual out-of-pocket expenses are minimized via lower deductibles or co-payment amounts, the actual cost of that group per enrolled member will be higher than if they had remained in a larger group with a significant number of healthy individuals over whom costs could be spread.

For example, assume the total annual claims cost on Modules 1 and 2 is $73,376,801 and there are 19,115 active employees enrolled in these two modules. The annual cost of claims per enrolled employee would be $3,839. Assuming the claims information noted in "*Did You Know?",* those with $0 to $500 in incurred claims account for 67% of the group, but only account for 4.2% of the total claims, or $3,094,300. If those individuals were to leave the group, the balance of claims would have to be funded by the remaining members. That means that the remaining 31% of the members would have to cover almost 96% of the claims cost, or $70,285,501. That would amount to $11,142 per employee per year ($70,285,501 divided by 6,308 employees).

### *Plan Enrollment FY 2001*

| | MODULE 1 | MODULE 2 | POS | TOTAL |
|---|---|---|---|---|
| **No. of Empl** | **5,452** | **13,414** | **249** | **19,115** |
| **% of Group** | **29%** | **70%** | **1%** | **100%** |

## Looking Ahead...



The IBHP plan for the contract effective July 1, 2002 is being remarketed. OIM will investigate funding alternatives and various cost management options which will be meaningful in helping the state contain the cost of the managed mental health/substance abuse benefit programs.

As part of the Department's website, OIM's homepage provides easy access to the information most often used by our employees and agency customers. The site contains the Employee Group Insurance Handbook, the newly revised Group Insurance Administration Manual (a procedural guide for HR/Payroll offices) copies of the Benefits Focus newsletter and other useful information related to the employee benefit programs administered by OIM.

Visit our website at **www2.state.id.us/adm/insurance**

### *DID YOU KNOW?*

*In the twelve month contract period ending 6/30/01 on the two Blue Shield Modules, in which 99% of all employees are enrolled:*

- *28% of the members submitted no claims and 39% of the group had claims that fell between $1 and $500. These two groups combined accounted for 67% of the total number of enrollees, but only 4.2% of the total plan costs (or $3,094,300).*
- *18% of the group incurred claims between $501 and $2,000, representing 12.8% of total claims, or $9,404,911.*
- *12% of the group had claims totaling between $2,001 and $10,000, accounting for 34.6% of total claims, or $25,382,859.*
- *48% of the total claims submitted against the group were generated by 2.75% of those covered. Total claims for this group equalled $35,494,731.*

### *Statutory Authority*

- The Director of the Department of Administration is "responsible for life, medical, disability, property, casualty, and other insurance as may be determined to be in the best interest of the State of Idaho by the Department of Administration."
- The director's objective is to "procure and maintain .... the most adequate group coverages reasonably obtainable for the money available for required premiums ...." (Idaho Code 67-5762).

**The director has the authority to:**

- "... employ additional personnel as may be necessary and may contract for professional or technical services or assistance when necessary and desirable." (Idaho Code 67-5760.)
- "... fix and promulgate rules for determining eligibility of personnel for participation in any group plans .... ",
- "... determine the nature and extent of needs for group life ...., group annuities, group disability insurance, and group health care service coverages ...., premiums or prepayments .... payable in whole or in part from funds of the State ...,"
- "... determine the types, terms, conditions, and amounts of group insurance ...," "negotiate and contract for, and have placed or continued .... all such insurance and coverages as may reasonably be obtainable ...,"
- "... may negotiate deductibles to any group plan or coverage. .... changes in such policies and contracts and renewal or termination thereof." (Idaho Code 67-5761)
- Idaho Code 67-5768 (2), states that "no policy or contract shall create, or be deemed to constitute, any financial obligation on the part of the State of Idaho beyond the obligation to contribute for or upon current premiums or prepayments thereof."